House Energy and Commerce, Health Subcommittee
Additional Questions for the Record
Answers prepared by Dr. Mitchell Lew

1. *The bipartisan, bicameral SGR bill has pretty strong incentives for physicians to take two-sided risk. Yet the only mature model in Medicare today where physicians truly take risk is in MA. Has the MA model been successful in providing better incentives for physicians and better care for patients? If so, do you think the coming cuts hurt the MA model?*

   A: The MA model has definitely been successful in providing better incentives for physicians and better care for patients. An adequately funded MA program is critically important in developing the infrastructure necessary for delivery reform and movement toward coordinated, value-based care. The impending cuts will have a direct and negative impact on the MA model and consequently, MA beneficiaries.

2. *Supporters of Obamacare often like to tout the law's handful of demonstration projects that experiment from capitated payments to providers. Can you talk about what your experience with capitated, accountable physician groups has been, and how it should inform the rest of Medicare? Do you think the goals of the capitation demos are similar to MA?*

   A: CAPG members have three decades of experience with capitation payments and the accountable care model it has created. Global capitation is an ambitious goal, but one that most of the American healthcare system should strive for. While the capitation demos are worth conducting, the real focus should be on MA, a proven model with a strong record of success.

3. *Some people suggest insurance companies are overpaid for MA and rates should be cut to fee-for-service levels for "equity." What do you think the impact of that will be on patients?*

   A: Eighty-five percent of MA funding is directed toward providers. Those providers and their patients will be severely harmed by cuts to the program. While the ACA now statutorily brings MA to parity with fee-for-service Medicare, that may be short-sighted. Since MA is a proven model and platform for delivery reform across the nation, it deserves investment and promotion.

4. *Would you explain concerns you have with the payment change for CY2015 related to the homebased health assessments?*

   A: Homebased health assessments are critical in providing quality care to MA beneficiaries, particularly those that are home or bed-bound. Home visits provide the best opportunity to identify lifestyle hazards, perform medication reconciliation and conduct dietary and nutritional assessments. That type of important information just isn't accessible during office visits.

5. *Only about 20% of the reductions to MA in the ACA have been phased in as of the end of this year. That means the bulk of the $300 B that is being taken out of the program will be cut in future years. What do you think the future of the program looks like in terms of access to doctors for seniors on MA?*

   A: Cuts of that size will inevitably and substantially reduce seniors' access to quality care. CAPG is deeply concerned that additional cuts will place the coordinated care model and infrastructure at risk.

6. *Generally speaking, do you think MA or fee-for-service Medicare is better health care for most seniors?*

   A: The MA program unequivocally delivers better care to seniors at lower costs and higher patient satisfaction rates than fee-for-service Medicare. Research shows MA beneficiaries are more likely to get preventative screenings, like mammograms, cholesterol screenings and eye tests for diabetes patients, than those in fee-for-service. MA beneficiaries also tend to have lower rates of preventable readmissions.

7. *Many elderly, frail, low-income individuals who are dually eligible for Medicare and Medicaid, are in special needs plans in the MA program. And at CMS, there is an effort to enroll many other "dual eligibles" in coordinated care plans or plans with capitated payments. From your perspective, would a dual get better care in FFS or MA?*

   A: Dual eligibles receive vastly better care in the MA program than they do in traditional Medicare. Duals tend to be sicker individuals with multiple chronic diseases who require a greater level of care coordination. The fragmented system in fee-for-service Medicare is particularly detrimental to those chronically ill patients who greatly benefit from the team-based approach of the MA model.